BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of: **Thomas J. Grade, M.D.,** -vs- Holder of License No. 10424 for the practice of allopathic Medicine in the State of Arizona, et al., Respondent.	No. MD-05-0253A MD-04-0540A MD-04-0459A **Interim Findings of Fact, Conclusions of Law and Order** **(Summary Restriction)**

The Arizona Medical Board having considered this matter at its public meeting December 7, 2005. After reviewing relevant information and deliberating, the Board considered proceedings for summary action against the license of Thomas J. Grade, M.D. appearing with legal counsel, Lisa Davis. Having considered the information in the matter and being fully advised, the Board enters the following Interim Findings of Fact, Conclusion of Law and Order for Summary Restriction of License pending formal hearing or other Board action pursuant to A.R.S. 32-1451(H).

INTERIM FINDINGS OF FACT

1. The Arizona Medical Board ("Board") is the duly constituted authority for licensing and regulating the practice of allopathic medicine in the State of Arizona.
2. Thomas J. Grade, M.D. ("Respondent") is the holder of License No. 10424 for the practice of allopathic medicine in the State of Arizona.
3. On May 13, 2005, the Board received a complaint from AM concerning the care and treatment rendered by Respondent to a 41-year-old female patient, LM, the daughter of the complainant. Board staff opened investigation number MD-05-0253A.
4. LM went to see Respondent on April 20, 2004, with a complaint of back pain. She

had been utilizing a spinal cord stimulator for pain relief and the battery had run out. She was referred to Respondent to replace the battery.

5. Respondent conducted a physical examination and reviewed LM's history including a listing of medications she was currently prescribed and taking.

6. Respondent scheduled LM for battery replacement on April 26, 2004 and prescribed Roxane Methadone 10 mg tablets with instructions to take one to three tablets four times per day for chronic pain. Respondent prescribed 200 tablets.

7. Respondent's office notes indicated that LM should start with five to ten mg per day and gradually increase the dose and replace the oxycontin she was taking with the methadone. However, the prescription read that LM should take a minimum of ten mg four times per day and could take as much as thirty mg four times per day.

8. At the time Respondent saw LM, she was already taking oxycontin 80 mg twice per day as well as multiple other medications including neurontin, zanaflex, paxil, amitriptyline and ambien.

9. Respondent did not discuss LM's treatment with her previous physician who had discharged LM for failing to adhere to stipulations in her narcotics contract.

10. Although Respondent says he advised LM about warnings for the medications, there is no mention of this within the patient medical charts. Respondent did not dictate the patient notes until April 29, 2004.

11. Respondent says that LM did not disclose all of the medications she was using at the time.

12. Respondent believed at the time that he was taking over LM's pain management. However, he did not obtain the patient's previous medical records at the time before prescribing the methadone and increasing the neurontin prescription.

13. On April 26, 2004, LM was found dead in her home. An autopsy concluded that

LM died from the toxicity of multiple drugs.

14. Standard of care requires a physician to maintain adequate records reflecting appropriate warnings regarding usage of prescription medications, obtain medical records from previous treating physicians to understand current treatment, to appropriately consider interaction of all medications and to appropriately introduce new opioid medication to a patient.

15. Respondent failed to record any discussions he had with LM relating to the precautions necessary when taking methadone, failed to obtain records from prior treating physicians, failed to appropriately prescribe methadone to indicate a gradual increase in dosage with a corresponding reduction in oxycontin.

16. On April 12, 2004, the Board received a complaint regarding Respondent's treatment of AH relating to pain management prescribing practices. Board staff opened investigation number MD-04-0459A.

17. The investigation concluded that Respondent failed appropriately document allegations of patient abuse of medications as well as quality of care issues by failing to monitor the patient's use of controlled substances for pain management and failure to initiate detoxification once alternative treatments were introduced.

18. On April 30, 2004, the Board received a complaint regarding Respondent's treatment of BE relating to pain management prescribing practices. Board staff opened investigation number MD-04-0540A.

19. The investigation concluded that Respondent failed to document physical examinations during his treatment of BE, failed to document current medications the patient was taking, failed to clearly outline treatment plans, advice, warnings or indications of how medications were to be changed, over-prescribed Oxycontin and Oxycodone with refill prescriptions written the same date as the original

prescriptions and failed to address the patient's tachycardia present on multiple visits.

INTERIM CONCLUSIONS OF LAW

20. The Board possesses jurisdiction of the subject matter hereof and over the Respondent, holder of license number 10424 for the practice of allopathic medicine in the State of Arizona.
21. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(e) "failing to maintain adequate records on a patient."
22. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(q) "Any conduct or practice which is or might be harmful or dangerous to the health of the patient or the public."
23. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(ll) "Conduct the Board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient."
24. Based on the foregoing Interim Findings of Fact and Conclusions of Law, the public health, safety or welfare imperatively requires emergency action. A.R.S. 32-1451(D).

ORDER

Based on the foregoing Interim Findings of Fact and Conclusions of Law, set forth above, IT IS HEREBY ORDERED THAT:

1. Respondent's license number 10424 for the practice of allopathic medicine in the State of Arizona is summarily restricted in that Respondent may not

prescribe Schedule II or III medications pending formal hearing before an Administrative Law Judge from the Office of Administrative Hearings.

2. The Interim Findings of Fact and Conclusions of Law constitute written notice to Respondent of the charges of unprofessional conduct made by the Board against him. The Respondent is entitled to a formal hearing to defend these charges as expeditiously as possible after the issuance of this Order.

3. The Executive Director is instructed to refer this matter to the Office of Administrative Hearings for scheduling an administrative hearing to be commenced as expeditiously as possible from the date of issuance of this Order, unless stipulated or agreed otherwise by Respondent.

DATED AND EFFECTIVE this 8 day of December, 2005.

Arizona Medical Board

(SEAL)

Timothy C. Miller, J.D.
Executive Director

Original filed this 8 day of December, 2005, with:

Arizona Medical Board
9545 East Doubletree Road
Scottsdale, AZ 85258

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Executed Copies of the foregoing were
Mailed By U.S. Certified Mail
this 8 day of December, 2005, to:

Ms. Lisa E. Davis, Esq.
Quarles & Brady Streich Lang, L.L.P.
Two North Central Avenue
Phoenix, Arizona 85004-2391
Attorney for Respondent

Thomas J. Grade, MD
6209 East Baywood Avenue
Mesa Arizona 85206-1744

Dean E. Brekke
Office of Arizona Attorney General
1275 W. Washington CIV/LES
Phoenix Arizona 85007